Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Corazon M. Ramirez, M.D., P.A. 6161 Harry Hines #224 Dallas, TX 75235	MFDR Tracking #: M4-07-2271-01 DWC Clai Injured En
Respondent Name and Box #: American Home Assurance Co. Rep Box: 19	Date of Inj Employer Insurance (

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: No position statement received.

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $156.32
3. CMS 1500
4. EOBs

Sent
JAN 15 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: " The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Principle Documentation:

1. Position Statement
2. Response to DWC 60 package
3. EOBs

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
06/30/06	W1, 42/W1, 42	01830-QZ	1-6	$146.85
Total Due:				$146.85

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to CPT code 01830-QZ for DOS 06/30/06.

2. This service was denied by the Respondent with denial reasons:

- W1 – "Workers Compensation State Fee Schedule Adjustment."
- 42 - "Charges exceed our fee schedule or maximum allowable amount."

3. This service was denied after reconsideration by the Respondent with denial reasons:

- W1 – "Workers Compensation State Fee Schedule Adjustment."
- 42 - "Charges exceed our fee schedule or maximum allowable amount."

4. Per Rule 134.202 (c) (1) the Respondent did not reimburse according to the MAR.

5. The MAR for procedure code 01830-QZ is as follows:

62 minutes ÷ 15 = 4.13 units = 4.1
CPT code 01830-QZ = 3.00 units + 4.1 units = 7.1 units
$47.37 (conversion factor) x 7.1 units = $336.33 (MAR)
$336.33 -$189.48 (Carrier paid) = $146.85

6. Therefore, according to rule 134.202(c) (1) reimbursement of $146.85 is recommended.

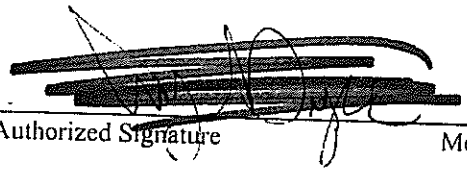
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $146.85 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:



[redacted]

Authorized Signature	Medical Fee Dispute Resolution Officer	01/11/08 Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.